BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: SHANQUIL W., Claimant, vs SAN GABRIEL/POMONA REGIONAL CENTER, Service Agency.	OAH Case No. 2006040016

DECISION

This matter was heard on June 2, 2006, at Pomona, California, by Joseph D. Montoya, Administrative Law Judge, Office of Administrative Hearings. Claimant was represented by Jennifer Waxler, Attorney at Law. The Service Agency, San Gabriel/Pomona Regional Center (SGPRC) was represented by Daniela Martinez, Fair Hearing Manager.

Evidence was received and the matter was argued, but the record was held open to allow Claimant to provide a signed copy of a report in place of the unsigned copy offered at the hearing. That document was received on June 7, 2006, and is received in evidence as Exhibit 3.

On June 9, 2006, the Service Agency submitted a written argument. The record was held open an additional 10 days to see if there would be any response from Claimant, but one was not forthcoming. Therefore, the written argument shall be identified for the record as Exhibit L. The matter was deemed submitted for decision on June 19.

STATEMENT OF ISSUES

The primary issue in this case is whether or not Claimant is eligible for services from the Service Agency on the basis of mental retardation, or under what is referred to as the "fifth category," that is, because he suffers from a condition similar to mental retardation, or that can be treated in a way similar to how mental retardation is treated. While it is undisputed that he has been diagnosed with significant disorders, whether he is eligible for

services under the relatively narrow confines of the Lanterman Act may turn on whether he suffers from a psychiatric disorder as asserted by the Service Agency, or whether he is in fact mentally retarded or afflicted with a similar condition, as asserted by Claimant.

FACTUAL FINDINGS

The Parties, Jurisdiction, and Procedural History:

1. Claimant is a boy of nearly 13 years[1] and a ward of the Superior Court. He currently resides in a group home and receives special education services, funded by his local school district. His interests in this matter have been represented by the Los Angeles County Department of Children's and Family Services (DCFS).

2. Mr. Tony Lorca, RN, PHN, of the DCFS, contacted the Service Agency on Claimant's behalf and requested re-consideration of eligibility under the Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code section 4500, et. seq. (Lanterman Act)[2]. (As detailed below, Claimant had previously been assessed, and eligibility denied.) On or about March 9, 2006, the Service Agency wrote Mr. Lorca, and notified him that it had determined that Claimant was not eligible for services. (Ex. A.) A timely request for a hearing was submitted, and this hearing ensued. There was no dispute that jurisdiction was established to proceed in this case[3].

Prior Eligibility Request:

3. Service Agency records indicate that Claimant was considered for Early Intervention services by the South Central Los Angeles Regional Center when he was approximately one year of age, but eligibility was denied. (Ex. B, p. 1, at 11/11/04 entry.) The California Early Intervention Services Act, Government Code section 95000 et. seq., provides services to children up to three years old who suffer from, or are at risk of suffering from developmental disabilities, so as to minimize delay. Eligibility under that program is broader than eligibility under the Lanterman Act.

4. In November 2004, the Service Agency assessed Claimant for eligibility under the Lanterman Act. On February 2, 2005, the Service Agency gave notice of its determination that Claimant, then 11 years old, was not eligible for services. (Ex. B., p. 2.) From the

[1] He was born December 11, 1993.

[2] All further statutory citations shall be to the Welfare and Institutions Code unless otherwise noted.

[3] The Fair Hearing Request form was not made part of the record, but notice is taken of the copy provided to OAH at the outset of the case. The request was dated March 20, 2006, and executed by Lora Marshall on Claimant's behalf.

record, it is reasonably inferred that Claimant did not request a fair hearing on that denial of eligibility. Instead, at some in late 2005 or early 2006, a request was made for re-assessment.[4]

Review of Prior Assessments of Claimant:

5. Service Agency staff reviewed several reports, evaluations, and assessments in the process of determining eligibility. Such reports have been received in evidence in this case. Overall, they reveal that Claimant is a troubled child, afflicted with serious disorders.

6. (A) The earliest assessment was prepared by Timothy D. Collister, Ph.D., a clinical psychologist, in March 2000. (Ex. F.) Claimant was then six years old. The assessment was requested by DCFS.

(B) The history taken by Dr. Collister was based on records then available, and statements of Claimant's social worker and foster mother. Dr. Collister repeated reports that Claimant might have depression, but more definitely showed a history of acting out, with or without provocation. His foster mother reported Claimant had been in a group home from approximately ages four to six, but was expelled for violent and destructive behavior, including threatening a teacher with a pair of scissors. While living with the foster mother, he would commit destructive acts on a daily basis, such as tearing down curtain rods and then systematically breaking them up, and he would defecate in the bedroom and places other than a toilet, including the floor of the classroom. He would act violently at least three times per day, and teachers informed the foster mother that he would bang his head on the floor or wall, threaten to hurt himself, and tantrum for up to an hour at a time. When confronted with his misbehavior at school, he would accuse the other children of lying.

(C) It was reported that Claimant had been diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) and was receiving medication at school. It is not clear who had generated that diagnosis.

(E) One of the several tests administered by Dr. Collister was the Wechsler Intelligence Scale for Children, Third Edition, commonly known as the WISC-III. The test yielded a verbal IQ score of 94, a performance IQ score of 71, and a full scale IQ of 81, placing Claimant in the Low Average Range. (Ex. F, p. 5.) Dr. Collister noted that the difference between the performance IQ and verbal IQ scores was significant, and raised the specter of "neuropsychological deficits, perhaps lateralized into the right hemisphere." (*Id.*) Claimant's verbal comprehension was solidly average, while his perceptual organization was in the fifth percentile, as was his distractability. His processing speed was in the delayed range, at the first percentile.

[4] The date of the request for reassessment is not shown in the record.

(F) Claimant reported auditory hallucinations during his interview with Dr. Collister. His anxieties prevented him from completing the Rorschach test, and other projective testing indicated significant anxieties. On a standard academic achievement test, reading and writing were in the average range, but math performance was in the mildly delayed range, falling at the third percentile, indicating a learning disorder that Dr. Collister speculated might be related to the neurophsychological disorder suggested by the WISC-III testing.

(G) Dr. Collister provided the following diagnostic impressions: Post-Traumatic Stress Disorder; Overanxious Disorder of Childhood; Psychotic Disorder, N.O.S. (not otherwise specified); ADHD, Learning Disorder (mathmatics, provisional); (Rule Out) Cognitive Disorder, N.O.S. On Axis II, where a diagnosis of mental retardation would be found, he deferred diagnosis. In the discussion that followed, Dr. Collister focused on Claimant's significant anxieties, evidence of psychosis including auditory hallucinations that appeared to command aggressive acts, Claimant's need for a neuropsycholical evaluation, and his tendency toward aggression. He recommended medication and psychotherapy, and educational programming that took into account Claimant's apparent learning disorder. He also recommended a group placement. Absent is anything that indicates that mental retardation was a possible diagnosis, and absent is recommendation for programming of the type that is provided to the mentally retarded.

7. (A) Three years after Dr. Collister evaluated Claimant, DCFS had him evaluated by Randi Elisa Bienstock, Psy. D., Q.M.E. At that point—March 2003—Claimant was living at Five Acres Residential Treatment and Foster Care Facility (Five Acres) and had been there since June 2000, or shortly after Dr. Collister's assessment was performed.

(B) In this assessment process, Dr. Bienstock had access to reports and other documents generated by the Five Acres facility, and was able to interview the supervisor of the cottage where Claimant was housed. Respondent was described as having a long history of problems including verbal and physical aggressive behaviors, inappropriate sexual behaviors, tantrums, and symptoms of anxiety and depression. (Ex. E., p. 2.) He had shown minimal progress at Five Acres, and on the night prior to the assessment, was trying to place his feces on other boys in the cottage. Despite weekly therapy, he continued to demonstrate problems understanding the serious nature of his aggression, which he tried to justify by blaming others. (*Id*., pp. 2-3.) Per a treatment plan developed in August 2002—about eight months before the assessment—he had been placed on Risperdal and Neurontin.

(C) Some testing was performed, including in the area of intellectual and academic functioning, but some of the tests had to be discontinued because of his behavior. To assess intellectual functioning, a Kaufman Brief Intelligence Test (Kaufman) was administered. Results demonstrated that his nonverbal skills were better developed than his verbal skills. A TONI-3 test, designed to assess nonverbal intelligence, was also administered, and it was consistent with the nonverbal part of the Kaufman. Overall, he showed an age equivalent of seven years, when he was nine years old. (Ex. E., p 9.) The numeric scores on these tests show below average, with an IQ composite of 80 on the

Kaufman, placing him in the ninth percentile. However, it appears that there is a substantial standard error of measurement in this test, as the score was given as 80, plus/minus 08. (*Id.*, p. 5.)

(D) For a diagnosis, Dr. Bienstock provided Depressive Disorder, NOS; Victim of Neglect by history; and Oppositional Defiant Disorder. There was no diagnosis on Axis II; put another way, she did not find mental retardation. (Ex. E., p. 12.)

8. (A) In January 2005, Claimant was assessed by Edward G. Frey, Ph.D, a clinical psychologist experienced in assessing developmental disabilities, including mental retardation. The assessment was at the request of the Service Agency, which was then considering the 2004 request for services. (Ex. G.)

(B) Dr. Frey noted that Claimant then was receiving six different medications, including Lithium, Depakote, and Risperdal. He also took note of the child's history of psychotic features, and his numerous maladaptive and anti-social behaviors. At that time Claimant was in fifth grade special education, qualifying for such due to "severe emotional problems." (Ex. E., p. 2.)

(C) At the time of the assessment, Claimant demonstrated "mild articulation and pronunciation problems" with expressive speech, though he could "easily communicate his needs and wants to others." He also demonstrated difficulty with attention and concentration, was highly distractible, but also acted as if heavily medicated. His motivation "seemed minimal."

(D) Dr. Frey attempted to administer the Wechsler Intelligence Scales for Children—IV, but could not because Claimant was described as quickly losing interest in the subtests. As to the subtests he did perform, he was described as doing "very poorly" on the coding sequence, and showed slight strength on abstract reasoning and short-term memory. However, there was no way to generate an IQ score with the WISC-IV in the circumstances. However, on the Test of Non-Verbal Intelligence—III (TONI-III) Claimant performed the test and was rated as having an IQ "falling at the upper borderline range," shown as an 84 in the table attached to the report. (Ex. E, pp. 3, 5.)

(E) Dr. Frey's diagnostic impressions were Bipolar Disorder and Post Traumatic Stress Disorder, both "by report," and Borderline Intellectual Functioning. (Ex. E, p. 3.) He stated that "current testing does not support a diagnosis of mental retardation at this point. . . . Clearly his bipolar diagnosis and associated psychotic symptoms are lowering his adaptive ability." (*Id.*, p. 4.)

9. (A) The most recent assessment was performed by staff at the facility where Claimant is residing, The Sycamores. (See Ex. H.) For the first time, he was diagnosed as suffering from mental retardation. And, a new series of Axis I diagnoses were found.

(B) The assessment was performed on December 19, 22, 28, and 29, 2005, by Courtney Cavanaugh, Ph.D. She states that Claimant was referred by a clinician and by a psychiatrist for a neuropsychological evaluation so as to provide diagnostic clarifications and treatment recommendations. "Of concern [were Claimant's] slurred speech, poor organization, impulsivity, tangential thinking, as well as poor memory, language skills, and intellectual abilities." (Ex. H., p. 1.)

(C) In discussing the genesis of the evaluation, it is noted that ". . . several prior medical reports [state] that Shanquil is a person with mental retardation, . . . " (Ex. H., p. 2.) However, those reports are not cited in the assessment report, and in a later section there is a reference to "the suspicions of several other physicians" that Claimant meets Regional Center eligibility criteria, that is, that he is retarded. (*Id*., p. 11, at "Recommendations.")[5]

(D) Among the many tests administered to Claimant was the WISC-IV, the IQ test that Dr. Frey had not been able to complete. Dr. Cavenaugh found a full scale IQ of 56. Claimant's Verbal Comprehension Index score was the highest, at 77, other key indices were lower. In the subtests, some scores were low, with comprehension the highest, at 7, and picture concepts the lowest, at 3. Two other subtest scores were at 4: block design and matrix reasoning. It must be noted that some of the subtest scores were similar to scores obtained by Dr. Frey before he was required to abort the testing of Claimant. That is, Dr. Frey obtained a score of 5 on the block design subtest, as opposed to the score of 4 derived by Dr. Cavenaugh; he had also obtained a score of 3 on the picture concepts subtest, as did Dr. Cavenaugh. Both assessors found a score of 6 on the similarities subtest. While Dr. Frey derived scores of 6 for digit span and a 2 for coding, Dr. Cavenaugh's report does not show scores for those subtests. (Compare Ex. G. at page 5 with Ex. H at p. 6.) Claimant's processing speed was very low, in the somewhere in the first percentile. (Ex.. H, p. 7.)

(E) The report speaks to Claimant's significant attention problems and distractability during the testing, described as follows:

> . . . he needed almost moment to moment redirection to remain on task. His ability to apply or sustain effort was minimal, his attention span was short, he was easily distracted by his own thoughts, ambient noise or room items and he was impulsive, leaving his seat, touching the examiner (nonsexually) and test items despite redirection not to do so. . . . Food reinforcement (sometimes after every item) and a number of breaks were utilized to complete testing, and some measures were discontinued due to them exceeding is ability or frustration level. . . . [Claimant]

[5] While a physician's medical exam did refer to Claimant as being mentally retarded, that report was generated in January 2006, after Dr. Cavenaugh's report. (See Ex. 2, dated January 18, 2006.)

> demonstrated particular difficulty completing tasks of memory in that he became physically overactive and complaining vehemently, asking this examiner "why are you doing this to me?"

(Ex. H., p. 6.)

(F) Dr. Cavenaugh listed her diagnostic impressions as Dysthymic Disorder, Neglect of Child, and Enuresis, Nocturnal Only, on Axis I, and Mild Mental Retardation on Axis II. It does not appear from the report that she had reviewed the prior assessments prepared by Collister, Bienstock, or Frey. While she noted that his special education services were provided on the basis of emotional disturbance, there was little comment on that finding, and if she reviewed the IEP (Individual Education Plan) documents, she did not discuss them.

(G) Dr. Cavenaugh opined that Claimant's relatively strong verbal skills belie his disability to some extent, leading others to expect more of him than he can provide. She believes that his history of prenatal exposure to cocaine, PCP, and alcohol would provide an explanation for mental retardation. She believes that his explosiveness and behavioral dysregulation is best understood within the context of mental retardation with Dysthymia and not Bipolar Disorder. His lack of progress, in Dr. Cavenaugh's opinion, should be attributed to mental retardation.

Educational History:

10. (A) Claimant has, in recent years, attended non-public special education facilities. As Dr. Cavenaugh noted, his eligibility for special education was based on a finding of extreme emotional disturbance, through the time of Dr. Cavenaugh's report. This is borne out in Individual Education Plans developed in 2003, 2004, and 2005. (See Ex's I, J, and K.) In his 2005 IEP, generated in October of that year, he is described as "continu[ing] to display dangerous and highly unsafe behavior" and in need of highly structured small group settings. (Ex. I, p.7.) He is also described, in terms of participation with peers who are non-disabled as displaying "poor peer interactions, impulsivity, assaultiveness (sic), and noncompliance issues." (*Id*.) He is later described as having made progress in all academic areas (*id*., p. 12) but it must be noted that his academic achievements, based on standardized testing, show him to rank no higher than the second percentile in any cluster score, and sometimes as low as in the one-tenth of the first percentile. (*Id*., p. 16.) Grade equivalents were first or second year even though Claimant was 12 years old. Absent from these documents is any indication that anyone has asserted that his educational problems are, in whole or in part, a result of mental retardation.

(B) The June 2006 IEP shows that eligibility criteria had changed, in that a mental retardation ground was added to the emotional disturbance criteria. (Ex. 1, p. 2.) Certainly his behaviors remained a challenge as of the time the latest IEP was generated. He is described as frequently defiant and even violent towards others, when any directive is

made. He is described as spitting, hitting, kicking, and even vomiting toward staff, and exclaiming that no one can tell him what to do. He articulates frustration with being unable to perform certain tasks. (*Id*., p. 9.) While much of his behavior is seen as responsive to commands, it is also seen as a device to obtain attention. (Id., p. 10.)

The Testimony of the Service Agency Experts:

11. (A) Claimant was unable to produce experts to testify in this matter. Two experts testified for the Service Agency: Dr. Frey, and Deborah Lagenbacher, Ph.D, who has been staff psychologist for the Service Agency for approximately nine years.

(B) Dr. Lagenbacher had reviewed a variety of prior assessments of Claimant, and she had participated on the eligibility team that determined whether Claimant was eligible for services. She acknowledged that 10 to 20 percent of the Service Agency clients who suffer from a developmental disability also suffer from a psychiatric disorder, and that psychiatric symptoms are not usually found in young children. However, based on the prior reports, she believes this child is so afflicted, and that his psychiatric problems, along with his significant attention problems, would tend to depress his test scores. She agreed that virtually all of the assessments show low adaptive functioning by Claimant. This includes daily living skills, reduced motor skills, learning, and self-direction, which are very low.

(C) Dr. Frey testified to the rather significant behavioral problems he observed during the testing, when it was impossible to obtain Claimant's full participation in that process. Regarding participation, Dr. Frey perceived that Claimant simply did not want to participate; at one point the boy was sitting with his eyes closed. During the one and one-half to two hours Dr. Frey spent with Claimant, he focused on potential autism, mental retardation, and fifth category eligibility. He attested that during testing of the boy's nonverbal skills, the boy was "concrete." Dr. Frey deems Claimant to be of borderline intelligence, but not mentally retarded or eligible under the fifth category.

Findings Pertaining to the Claim of Mental Retardation:

12. (A) As set forth in the leading diagnostic manual, there are two essential elements to mental retardation. The first is significantly sub-average general intellectual functioning (Criterion A), accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B)[6]. (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association,* page 41, hereafter DSM.) The DSM goes on to point out that depending on the testing instrument

[6] As noted hereafter, the Lanterman Act and related regulations require a finding of handicaps in three areas, rather than in two.

used, an IQ score as high as 75 can support a diagnosis of mental retardation if the criteria of significant limitations in adaptive functioning are met; this reflects the margin of error in the testing. (*Id*., pp. 41-42.)

(B) The authors of the DSM note the following about IQ test results:

> When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

(DSM, at p. 42.)

(C) The DSM defines adaptive functioning as "how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. . . . Problems in adaption are more likely improve with remedial efforts than is the cognitive IQ, which tends to remain more stable." (Ibid., p. 42.)

(D) The DSM sets out degrees of severity of mental retardation, where mild mental retardation refers to an IQ level of 50-55 to approximately 70. Moderate mental retardation refers to the area from IQ levels 30 to 35 and 50 to 55. Those suffering from mild mental retardation are described as able to acquire, by their late teens, academic skills that may rise to the sixth-grade level, and it is pointed out that, with proper supports, they can become able to live successfully in the community, either independently or with some supports. Those with moderate mental retardation acquire communication skills during early childhood years, and can profit from vocational training, but are unlikely to progress past the second-grade level in academic subjects. In adolescence, their inability to recognize social conventions can lead to difficulties in peer relationships, but by adulthood they can perform unskilled or semiskilled work under supervision; living arrangements must be in a supervised situation. (Ibid., pp. 42-43.)

(E) Individuals with mental retardation exhibit a prevalence of comorbid mental disorders at a rate estimated to be three to four times that of the general population. That may flow from shared etiology common to retardation and the other disorder. All types of disorders may be seen, but the most common associated mental disorders are ADHD, Mood Disorders, Pervasive Developmental Disorders, Stereotypic Movement Disorder, and Mental Disorders Due to a General Medical Disorder. (Ibid, p. 45.)

(F) To obtain a diagnosis of mental retardation, the onset must occur before the age of 18. In some cases a person with mild mental retardation may, through training and opportunities, develop such good adaptive skills as to no longer have the level of impairment necessary to qualify for the diagnosis.

14. There is no doubt that Claimant's condition arose before his 18th year. There is no real dispute that he suffers significant impairments in present adaptive functioning in several areas, below what would be expected from a boy of his age, including in the areas of self-care, home living, social/interpersonal skills, self-direction, functional academic skills, health, safety, and use of community resources. (See, e.g., Factual Findings 1, 6(B), 6(C), 6(F), 7(B), 10, & 11(B).)

15. (A) In the area of overall intellectual functioning, there are conflicting IQ scores, and the most recent test results raise as many questions as they answer. For example, missing from Dr. Cavenaugh's report, which was apparently geared toward obtaining regional center services, is any analysis of Dr. Collister's findings regarding Claimant's IQ. This in turn leaves unanswered a rather obvious question: how a drop in overall IQ, from 81 to 56, can be explained, especially where the DSM points out that IQ tends to be stable. (See Factual Fining 13(C), above.) There is no evidence that Dr. Collister, who completed the IQ test in 2000 for DCFS, bungled the job in any way, and thus the IQ score he derived can not be ignored. At the same time, Dr. Cavenaugh's report indicates that her methodology—four days of testing with constant re-direction to task—may not have been performed in the expected manner, that is, in a manner consistent with the methodology used by the creators of the test to establish the test's reliability and validity. Such a change in methodology could account for the overall discrepancy between the overall IQ scores obtained by Dr. Collister and Dr. Cavenaugh.

(B) While Claimant has some rather significant adaptive limitations, he is not without some strengths, including his ability to communicate verbally, as witnessed by the ALJ during the hearing. Dr. Cavenaugh reports an IQ right at the border of what has traditionally been delimited as moderate retardation—an IQ of 55 and below, the bottom one percent of the general population. In a case where many who have interacted with, or assessed Claimant, have not perceived him as retarded at all, such a low score—essentially another standard deviation below the line that defines mental retardation generally—appears surprising. While Dr. Cavenaugh states that his verbal abilities tend to belie his cognitive limitations, it may also be said that those skills are not consistent with such a low IQ score.

16. It does not appear that all of Claimant's behavioral problems are a function of mental retardation. As Dr. Frey stated, Claimant's adaptive problems appear to result from his psychiatric issues, and not from mental retardation. There is no evidence that his violent and scatological behavior, described to Dr. Collister and to others, was a function of some global cognitive delay, and the contrary appears to be the case. Thus, it does not appear that he tried to put feces on the other people he shared the Five Acres group home with because he was mentally retarded; it appears that such behavior was the result of psychiatric issues. (See Factual Finding 7(B).) This is not to say there are not elements of such delays present, but it is to say that such do not explain all of his extreme behaviors.

17. Notwithstanding the diagnosis provided by Dr. Cavenaugh, based on the entire record, it is found that Claimant is not mentally retarded.

On Fifth Category Eligibility:

18. The Lanterman Act, at section 4512, subdivision (a), defines developmental disabilities as follows:

> "Developmental disability" means a disability which originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . this term shall include mental retardation, . . . *This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature*. (Emphasis added.)

This latter category is commonly known as "the fifth category."

19. In this case the record establishes that Claimant suffers from a condition similar to mental retardation. His handicapping conditions are not solely physical, nor are they solely a function of his psychiatric issues and learning disorder, and they can be expected to continue indefinitely.

20. While Respondent has scored as high as an 81 in his overall IQ when a standard testing instrument has been used, it can not be forgotten that one component of that score was a 71, and that there was a 23-point difference between that score and the other subcomponent. (See Finding 6(E), above.) As noted in the DSM, when there is a marked discrepancy between the performance and verbal IQ scores, averaging can be misleading. (See Finding 14(B), above.)

21. There can be no doubt that Claimant suffers from significant cognitive delays, especially in regard to coding and processing speed, which virtually all who assessed him found to be within the first percentile. (See e.g., Factual Findings 6(E), 8(D), 9(D).) Likewise, the subtests that Dr. Frey was able to perform tended to show significantly low scores. While Claimant may not be clearly mentally retarded, it can not be seriously asserted that his general cognitive skills are not impaired. His situation is very similar to a person with mental retardation: he has significant cognitive limitations, and his adaptive skills are hampered as well. Some of the issues that prevent him from learning, or interacting, such as distractability, can be said to be within the constellation of problems typically associated with retarded persons.

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LEGAL CONCLUSIONS

1. Jurisdiction exists to conduct a fair hearing in the above-captioned matter, pursuant to Code section 4710.5, based on Factual Findings 1 and 2.

2. Claimant bears the burden of establishing that he is eligible for services under the Lanterman Act. (Evid. Code, §500.)

3. The Code, at section 4512, subdivision (a), defines developmental disabilities within the meaning of the Lanterman Act as follows:

> "Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

This latter category is commonly known as the fifth category, although it really encompasses two eligibility sub-categories.

4. (A) Regulations developed by the Department of Developmental Services (DDS), pertinent to this case, are found in title 17 of the California Code of Regulations (CCR). At section 54000 a further definition of "developmental disability" is found. There the term is defined to include mental retardation, cerebral palsy, epilepsy, autism, or "other conditions similar to mental retardation that require treatment similar to that required by mentally retarded individuals."[7] The developmental disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial handicap for the individual.

(B) Under the regulations, some conditions are excluded. They are:

> (1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

[7] The regulation tends to require that the consumer or potential consumer of services have both conditions—a condition similar to mental retardation *and* a condition that requires treatment similar to that required by the mentally retarded—in order to be eligible under the fifth category. That conflicts with the statute, which makes eligibility in the alternative. In such a case the statute must control.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

5. (A) The statutory scheme was amended in 2003, making a change in the definition of substantial disability, and shortly thereafter the regulations were amended as well. The regulation defining substantial disability is found at CCR section 54001, subdivision (a), and states that:

"Substantial disability" means:
(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Communication skills;
(B) Learning;
(C) Self-care;
(D) Mobility;
(E) Self-direction;
(F) Capacity for independent living;
(G) Economic self-sufficiency.

6. Based on the foregoing, it must be found that Claimant has a substantial disability within the meaning of the law. This Conclusion is based on Factual Findings 1, 6(B), 6(C), 6(F), 7(B), 10, 11(B), and 14.

7. (A) Although Claimant has established he is substantially disabled as that term is used under the law, he must still establish that his disability is connected to an eligible condition, in this case either mental retardation or the fifth category. Claimant has not carried his burden at this time of establishing that he is mentally retarded and therefore

entitled to benefits under the Lanterman Act under that eligibility. This Conclusion is based on Factual Findings 6(A) through 6(G), 7(A) through 7(D), 8(A) through 8(E), 12(A) through 17, and Legal Conclusions 1 through 5.

(B) Claimant has carried his burden of proving he suffers from a condition similar to mental retardation, based on Factual Findings 6(A) through 11, and 18 through 21.

8. Based on Legal Conclusions 6 and 7, and their factual predicates, and section 4512(a), Claimant is eligible for regional center services.

ORDER

The Claimant's appeal is granted, and he shall be eligible for services from the Service Agency on the basis that he suffers from a condition similar to mental retardation.

July 13, 2006

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Joseph D. Montoya
Administrative Law Judge
Office of Administrative Hearings

NOTICE

THIS IS THE FINAL ADMINISTRATIVE DECISION IN THIS MATTER, AND BOTH PARTIES ARE BOUND BY IT. EITHER PARTY MAY APPEAL THIS DECISION TO A COURT OF COMPETENT JURISDICTION WITHIN 90 DAYS OF THIS DECISION.